UNIVERSITY of CALIFORNIA, SAN DIEGO
MEDICAL CENTER

HISTORY
ORTHOPAEDIC MEDICINE

Patient Identification

Chief Complaint

Why are you seeing the doctor today? _____

What was the date of your injury? _____

What makes your problem better? _____

What makes your problem worse? _____

Have you seen another doctor for this problem? ❒ Yes ❒ No

If yes: Name _____

Type of Doctor _____

Date _____

Have you had any previous treatment for this problem? ❒ Yes ❒ No

❒ Physical Therapy ❒ Medications ❒ Chiropractor ❒ Acupuncture ❒ Other _____

Current problem is the result of: *(Check all that apply)*

❒ Lifting ❒ Pulling ❒ Pushing ❒ Twisting ❒ Falling ❒ Bending
❒ Reaching ❒ Squatting ❒ Hit by object ❒ Not known

Are you: ❒ right handed ❒ left handed

Past Medical History *(List all health problems)*

1. _____
2. _____
3. _____

Surgical History *(List all previous surgeries)*

1. _____
2. _____
3. _____

Medications (review on Medication Reconciliation Ambulatory Care form)

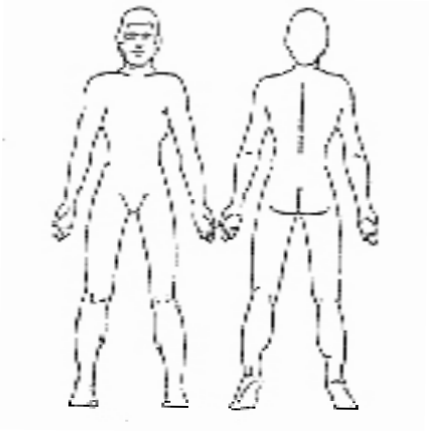
Allergies/Reactions

_____

_____

_____

Please mark where you have pain



R L L R

Pain Complaint

Intensity (0-10) _____ Location _____

Quality _____

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Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)				
Grandfather (mom's)				
Grandmother (dad's)				
Grandfather (dad's)				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Social History

❒ Work in home ❒ Employed (occupation: _____) ❒ Student

❒ Single ❒ Married ❒ Registered Domestic Partner ❒ Divorced ❒ Separated ❒ Widowed

Children? ❒ No ❒ Yes # of children _____

Do you live alone? ❒ No ❒ Yes

Exercise? ❒ Daily ❒ Weekly ❒ Monthly ❒ Rarely ❒ Never

What type of exercise? _____

Are you on a special diet? ❒ No ❒ Yes Describe: _____

History of substance abuse? ❒ No ❒ Yes What? _____

Smoking currently? ❒ No ❒ Yes _____ Packs per day _____ Years

Quit Smoking? ❒ This year ❒ > 1 year ❒ > 5 years ❒ >10 years

Previously smoked?_____ Packs per day _____ Years

Drink alcohol? ❒ Daily ❒ 1-2 x week ❒ 1-2 x month ❒ 1-2x year

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Patient Identification

Review of Systems

Are you currently or have you had problems with:

	Circle		Please describe all **YES** answers
Ears, Nose, Throat	No	Yes	_____
Eye	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder problem	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding problems	No	Yes	_____
Numbness/tingling	No	Yes	_____
Blackout/fainting	No	Yes	_____
Psychological problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

Patient Signature: _____ Date/Time: _____

❒ Assessed for signs & symptoms of abuse (e.g., sexual/physical/financial)

Reviewed By: _____ Date/Time: _____